STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505355	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Post Acute	414 - 17th Southeast Auburn, WA 98002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to provide adequate supervision to 1 (Resident 1) of 3 residents reviewed for elopement and accidents. The facility failed to provide supervision to Resident 1. These failures placed Resident 1 at a potential risk of harm, injury, and avoidable accidents. The facility has corrected the above deficiency prior to the abbreviated survey and constituted as past non-compliance (the facility was not in compliance at the time the incident occurred; there was sufficient evidence the facility corrected the supervision failures after it was identified) and is no longer outstanding. Findings included.Review of the facility policy, titled Elopements and Wandering Residents, dated 2025, showed the facility would ensure residents who exhibited wandering behavior and/or was at risk for elopement would receive adequate supervision to prevent accidents. The policy showed door and wander guard alarms were not a replacement for necessary supervision and staff should be vigilant in responding to alarms in a timely manner. When a resident was missing the elopement/missing resident emergency procedure code white (missing resident) would be initiated. The procedure included searching the facility and the outdoor premises. If the resident was not located the facility would notify the Director of Nursing (DON), the Administrator, the resident representative, the physician, and local law enforcement. <Resident 1>Review of Resident 1's quarterly Minimum Data Set (MDS, an assessment tool), dated 07/31/2025, showed Resident 1 had severe cognitive impairment and was not able to make their own decisions. The MDS showed Resident 1 had diagnoses including dementia, high blood pressure, anxiety, and muscle weakness. The MDS showed Resident 1 used a wheelchair for mobility and required staff supervision with transfers and toileting.Review of physician orders, dated 04/09/2024, directed staff to perform safety checks on Resident 1 every shift for elopement and wandering risk.Review of a facility elopement assessment, dated 05/01/2025, showed Resident 1 was at high risk for an elopement. The assessment showed Resident 1 had a history of wandering and exit seeking, with a history of an elopement from the facility.Review of Resident 1's elopement Care Plan (CP), revised on 08/03/2025, showed Resident 1 had a history of attempts to leave the facility unsupervised. The CP directed staff to distract the resident from wandering by offering pleasant diversions, such as activities, food, conversation, television, or a book. The CP showed Resident 1 had a wander guard (bracelet device that sets an alarm off when close to an unsafe area like the elevator or exit door) to the left wrist and directed staff to perform safety checks every two hours, and document Resident 1's location.Review of a facility investigation, dated 08/03/2025, showed on 08/02/2025 at 8:32 PM Resident 1 who resided on the second floor with a wander guard in place, when they eloped from the facility front door unnoticed, went missing for nine hours before staff noticed, was found in the community thirteen hours later, and was alone and unsupervised in the community for twenty two hours. The investigation showed Staff B (DNS) was notified at 5:52 AM, nine hours later that Resident 1 could not be located in the facility by Staff C (Licensed Practical Nurse, LPN). The investigation showed that Staff D (Certified Nurse's Assistant assigned to Resident 1 on 08/02/2025 from 2pm to 08/03/2025 at 6 am) were interviewed and stated they last saw Resident 1 around midnight in the resident's room. (Review of the security footage did not show Resident 1 returning to the facility.) The investigation showed on 08/03/2025 at 7:10 PM Staff B was notified that a phone call was received that a person that fit the description of the resident was found down the street in a residential backyard. A neighbor confirmed Resident 1 was seen on 08/02/2025 at 9:15 PM in the same spot where they were discovered on 08/03/2025 at 7:10 PM. The investigation showed Resident 1 was sent to the hospital for an evaluation that showed a minor skin issue. Review of Resident 1's clinical record showed on 08/02/2025, Staff C documented every half hour from 6:30 PM to 6:00 AM on 08/03/2025 that safety checks were performed on Resident 1.In an observation and interview on 08/11/2025 at 2:00 PM, Resident 1 was observed sitting in their wheelchair in their room with a wander guard bracelet on the left wrist. When asked what happened to their upper right arm, Resident 1 stated they did not recall. Resident 1's right upper arm was observed with slightly red discoloration and scabbed areas. When asked about the elopement Resident 1 was not able to give any details or information as they did not recall the incident. Attempts to interview Resident 1's collateral contact were unsuccessful. During an interview on 08/18/2025 at 11:42 AM, Staff A (Administrator) stated the facility front doors were locked and an alarm was triggered when the door push bar was engaged and someone exited the facility. Staff A stated when a resident was not located in the facility, they would expect staff to follow the facility's protocol and activate a code white. When the resident was not found within fifteen minutes staff were